STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005015	A. BUILDING: _____ B. WING _____	01/07/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST ANTHONY HEALTH - MICHIGAN CIT	301 W HOMER ST MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was for a State hospital complaint investigation. Date of Survey: 01/07/2015 Facility Number: 005015 Complaint # IN00155992 Unsubstantiated; lack of sufficient evidence. Surveyor: Albert Daeger, Medical Surveyor Franciscan St. Anthony Health - Michigan City is in compliance with 410 IAC 15-1.5-1, Dietetic Services and 410 IAC 15-1.5-2, Infection Control, Hospital Licensure Rules. QA: claughlin 03/11/15	S 000		